

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-08 Medicare Program Integrity</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 158</b>	<b>Date: SEPTEMBER 15, 2006</b>
	<b>Change Request 5076</b>

**SUBJECT: Provider Enrollment Disenrollment Actions**

**I. SUMMARY OF CHANGES:** These instructions add several revocations and clarify Revocations 1 through 8. In addition, this CR clarifies that deactivation can be used for all provider and supplier types.

**NEW / REVISED MATERIAL**

**EFFECTIVE DATE: OCTOBER 1, 2006**

**IMPLEMENTATION DATE: OCTOBER 2, 2006**

*Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.*

**II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)**

**R=REVISED, N=NEW, D=DELETED**

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
<b>R</b>	10/Table of Contents
<b>N</b>	10/13/Provider Enrollment Disenrollment Actions
<b>N</b>	10/13.1/Deactivation of Billing Numbers
<b>N</b>	10/13.2/Contractor Issued Revocations

**III. FUNDING:**

**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budget.**

**IV. ATTACHMENTS:**

**Business Requirements  
Manual Instruction**

*\*Unless otherwise specified, the effective date is the date of service.*

## Attachment - Business Requirements

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**SUBJECT: Provider Enrollment Disenrollment Actions**

## I. GENERAL INFORMATION

**A. Background:** These instructions revise and update the reasons a fee-for-service contractor can deactivate or revoke a provider or supplier's Medicare billing privileges. In addition, this CR clarifies that deactivation can be used for all provider and supplier types.

**B. Policy:** 42 CFR 424.82 and 42 CFR 424.535 provide justification for these revisions.

## II. BUSINESS REQUIREMENTS

*"Shall" denotes a mandatory requirement*

*"Should" denotes an optional requirement*

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
5076.1	When the affiliated contractor determines the revocation is warranted, the affiliated contractor shall provide sufficient information to the provider/supplier to enable provider/supplier to challenge the revocation determination.	X	X	X	X					NSC
5076.1.1	When the affiliated contractor determines the revocation is warranted, the affiliated contractor shall notify the provider/supplier in writing.	X	X	X	X					NSC
5076.1.2	When the affiliated contractor determines the revocation is warranted, the affiliated contractor shall afford the provider or supplier appeal rights.	X	X	X	X					NSC

### III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)
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		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
	None									

#### IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

##### A. Other Instructions: N/A

X-Ref Requirement #	Instructions

##### B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

##### C. Interfaces: N/A

##### D. Contractor Financial Reporting /Workload Impact: N/A

##### E. Dependencies: N/A

##### F. Testing Considerations: N/A

#### V. SCHEDULE, CONTACTS, AND FUNDING

<b>Effective Date*:</b> October 1, 2006  <b>Implementation Date:</b> October 2, 2006  <b>Pre-Implementation Contact(s):</b> August Nemec 410-786-0612  <b>Post-Implementation Contact(s):</b> August Nemec 410-786-0612	<b>No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.</b>
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# **Medicare Program Integrity Manual**

## **Chapter 10 - Healthcare Provider/Supplier Enrollment**

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### **Table of Contents** *(Rev. 158, 09-15-06)*

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  - 13.1 – Deactivation of Billing Numbers***
  - 13.2 – Contractor Issued Revocations***

### **13 – Provider Enrollment Disenrollment Actions**

**(Rev. 158, Issued: 09-15-06; Effective: 10-01-06; Implementation: 10-02-06)**

*If circumstances warrant, a fee-for-service contractor shall deactivate or revoke a provider or supplier's Medicare billing privileges under certain circumstances. Deactivation or revocation of Medicare billing privileges will not impact a provider or supplier's ability to submit claims to non-Medicare payers using their National Provider Identifier.*

#### **13.1 – Deactivation of Billing Numbers**

**(Rev. 158, Issued: 09-15-06; Effective: 10-01-06; Implementation: 10-02-06)**

*The deactivation of Medicare billing privileges does not effect a provider or supplier's participation agreement.*

*Fee-for-service contractors may deactivate a provider or supplier's Medicare billing privileges when:*

- A provider or supplier does not submit any Medicare claims for 12 consecutive calendar months. The 12 month period will begin the 1<sup>st</sup> day of the 1<sup>st</sup> month without a claims submission through the last day of the 12<sup>th</sup> month without a submitted claim,*
- A provider or supplier fails to report a change to the information supplied on the enrollment application within 90 calendar days of when the change occurred. Changes that must be reported include, but are not limited to, a change in practice location, a change of any managing employee, and a change in billing services; or*
- A provider or supplier fails to report a change in ownership or control within 30 calendar days.*

#### *Deactivation of billing privileges.*

*Providers and suppliers deactivated for non-submission of a claim are required to complete and submit a Medicare enrollment application to recertify that the enrollment information currently on file with Medicare is correct and furnish any missing information as appropriate. The provider or supplier must meet all current Medicare requirements in place at the time of reactivation, and be prepared to submit a valid Medicare claim.*

*Providers and suppliers who fail to promptly notify a fee-for service contractor of a change must complete and submit a complete Medicare enrollment application to reactivate its Medicare billing privileges or, when deemed appropriate, recertify that the enrollment information currently on file with Medicare is correct.*

*Reactivation of Medicare billing privileges does not require a new State survey or the establishment of a new provider agreement.*

### **13.2– Contractor Issued Revocations**

**(Rev. 158, Issued: 09-15-06; Effective: 10-01-06; Implementation: 10-02-06)**

*Fee-for-service contractors may issue a revocation (or recommend a revocation to the appropriate regional office) in Section 13.2 using revocations reasons 1 through 13 without prior approval by CMS.*

*Whenever a decision is made by a contractor to revoke (or recommend a revocation), they are required to fully and clearly document the reason(s) for the revocation. If there is more than one reason to revoke a provider or supplier's Medicare billing privileges, the contractor or RO should describe each reason for revocation in the letter sent to the provider or supplier. Contractors should always support revocation decisions citing the appropriate statute, regulatory or manual instruction. In addition, a contractor's revocation letter must contain information regarding a provider or supplier's appeal rights.*

*Revocations become effective within 30 days of the initial revocation date noted in the letter.*

*Anytime a provider or supplier number is revoked, contractors must maintain documentation as required in Section 21, Retention of Records, of this chapter.*

#### *Revocations based on non-compliance:*

*Revocation 1:* *The provider or supplier is determined not to be in compliance with the enrollment requirements described in this section or in the applicable enrollment application for its provider or supplier type and has not submitted a plan of corrective action. Noncompliance includes but is not limited to the provider or supplier no longer having a physical business address or mobile unit where services can be rendered and/or does not have a place where patient records are stored to determine the amounts due such provider or other person and/or the provider or supplier no longer meets or maintains general enrollment requirements. All providers and suppliers are granted an opportunity to correct the deficient compliance requirement prior to a final determination to revoke billing privileges.*

*(i) CMS may request additional documentation from the provider or supplier to determine compliance if adverse information is received or otherwise found concerning the provider or supplier.*

*(ii) Requested additional documentation must be submitted within 60 calendar days of request.*

*The provider, supplier, owner, partner, managing organization/employee, officer, director, medical director, and/or delegated or authorized official is excluded from a Federal program (as set forth in either §1862(e)(1) of the Social Security Act (the act);*

*42 U.S.C. §1395y(e)(1), 42 C.F.R. §1001.1001, §1001.1901 or is/are debarred from participating in a Federal procurement or non-procurement program; (as set forth in §2455 of the Federal Acquisition Streamlining Act of 1994, Pub. L. No. 103 55 (1994).*

*Revocation 2: The provider or supplier has lost its license(s) or is not authorized by the Federal/state/local government to perform the services for which it intends to render. (In the revocation letter or recommendation to revoke, list appropriate citations, e.g., §1861(r) or §1861(s) of the Act.*

*Revocation 3: The provider or supplier no longer meets CMS regulatory requirements for the specialty for which it has been enrolled. (In the revocation letter, list appropriate regulation.)*

*Revocation 4: The provider or supplier (upon discovery) does not have a valid SSN/employer identification number for itself, an owner, partner, managing organization/employee, officer, director, medical director, and/or delegated or authorized official.*

*Revocations based on provider or supplier conduct:*

*Revocation 5: The provider or supplier, or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier is:*

*(i) Excluded from the Medicare, Medicaid, and any other Federal health care program, as defined in §1001.2 of this chapter, in accordance with section 1128, 1128A, 1156, 1842, 1862, 1867 or 1892 of the Act.*

*(ii) Is debarred, suspended, or otherwise excluded from participating in any other Federal procurement or nonprocurement program or activity in accordance with the FASA implementing regulations and the Department of Health and Human Services nonprocurement common rule at 45 C.F.R. part 76.*

*Anytime an excluded party is found, notify DPSE immediately. DPSE will notify the Government Task Leader (GTL) for the appropriate PSC. The GTL will, in turn, contact the Office of Inspector General's office with the findings for further investigation.*

*Revocations based on felony:*

*Revocation 6: The provider, supplier, or any owner of the provider or supplier, within the 10 years preceding enrollment or revalidation of enrollment, was convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries to continue enrollment.*

*(i) Offenses include—*

*(A) Felony crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.*

*(B) Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions*

*(C) Any felony that placed the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.*

*(D) Any felonies that would result in mandatory exclusion under section 1128(a) of the Act.*

*(ii) Revocations based on felony convictions are for a period to be determined by the Secretary, but not less than 10 years from the date of conviction if the individual has been convicted on one previous occasion for one or more offenses.*

*Revocations based on false or misleading information:*

*Revocation 7:* *The provider or supplier certified as “true” misleading or false information on the enrollment application to be enrolled or maintain enrollment in the Medicare program. (Offenders may be subject to either fines or imprisonment, or both, in accordance with current law and regulations.) If it is discovered that the provider or supplier deliberately falsified, misrepresented, or omitted information contained in the application or deliberately altered text on the application form, issue a revocation or recommendation for revocation.*

*Revocations based on misuse of billing number:*

*Revocation 8:* *The provider or supplier knowingly sells to or allows another individual or entity to use its billing number. This does not include those providers or suppliers who enter into a valid reassignment of benefits as specified in §424.80 or a change of ownership as outlined in §489.18 of this chapter.*

*(b) Effect of revocation on provider agreements. When a provider’s or supplier’s billing privilege is revoked, any provider agreement in effect at the time of revocation is terminated effective with the date of revocation.*

*Additional revocation reasons:*

*Revocation 9:* *CMS determines, upon on-site review, that the provider or supplier is no longer operational to furnish Medicare covered items or services, or is not meeting Medicare enrollment requirements under statute or regulation to supervise treatment of,*



*or to provide Medicare covered items or services for, Medicare patients. Upon on-site review, CMS determines that—*

*(i) A Medicare Part A provider is no longer operational to furnish Medicare covered items or services, or the provider fails to satisfy any of the Medicare enrollment requirements.*

*(ii) A Medicare Part B supplier is no longer operational to furnish Medicare covered items or services, or the supplier has failed to satisfy any or all of the Medicare enrollment requirements, or has failed to furnish Medicare covered items or services as required by the statute or regulations.*

*Revocation 10: The provider or supplier fails to furnish complete and accurate information and all supporting documentation within 60 calendar days of the provider or supplier's notification from CMS to submit an enrollment application and supporting documentation.*